International Journal of Infectious Diseases 14 (2010) e271–e272

Contents lists available at ScienceDirect

International Journal of Infectious Diseases

journal homepage: www.elsevier.com/locate/ijid

Medical Imagery

Cutaneous histoplasmosis as initial presentation of AIDS

Vanessa Santos Cunha *, Patrícia R. Pereira, Eduardo Sprinz

Hospital de Clínicas de Porto Alegre, Ramiro Bracelos Street, 2350 Porto Alegre, Rio Grande do Sul, Brazil

ARTICLE INFO

Article history:
Received 16 March 2009
Received in revised form 30 March 2009
Accepted 13 April 2009

Corresponding Editor: William Cameron, Ottawa, Canada

Figure 1. Erythematous papules on the face in a patient with histoplasmosis.

Figure 2. After one month of treatment: there is a noticeable improvement in the facial lesions.

A 43-year-old previously healthy woman was admitted to our hospital with disseminated cutaneous lesions that had started one month ago. There were several erythematous papules on the face (Figure 1) and lesions on the arms, legs, and trunk that formed plaques and crusts. She also complained of fever and weight loss that appeared along with the cutaneous lesions. A cutaneous biopsy was performed and the lesions were cultured. The patient consented to an HIV serology test, which was positive. Culture of the lesions showed *Histoplasma capsulatum* and she started treatment induction with amphotericin B and deoxycholate,

* Corresponding author. Tel.: +55 51 30234494; fax: ++55 51 30234494.
E-mail address: vscunha@yahoo.com (V.S. Cunha).

doi:10.1016/j.ijid.2009.04.010

followed by consolidation with itraconazole. She was also started on tenofovir, lamivudine, and efavirenz. Despite poor adherence to therapy at home, there was great improvement of the cutaneous lesions (Figure 2).

H. capsulatum is acquired by inhalation of mycelia and microconidia fragments of the fungus. The fungus lives in the soil, next to rivers, and next to birds and bats, which carry it in the gastrointestinal tract. The disease is often self-limited or localized in the general population, but may be disseminated and fatal in patients with pre-existing conditions, especially those related to immunosuppression.[1] In HIV-positive patients, it is usually described with CD4 lymphocyte counts lower than 150 cells/mm^3 (as in our case, which was 124 cells/mm^3). It is important to note that the cutaneous lesions can vary in shape, consistency, and number in these individuals.[2]

Other diseases can produce cutaneous lesions in HIV patients in this clinical setting and should be included in the differential diagnosis. Drug eruptions, HIV-associated prurigo, scabies, psoriasis, and other bacterial, viral, and fungal diseases are some of the disorders that can mimic cutaneous histoplasmosis. Therefore, the identification and isolation of the fungus in tissues is essential for the correct diagnosis.[3]

Different studies in different hospitals have shown that *H. capsulatum* strains from South America have greater dermotropism, with more mucocutaneous changes, compared with those from North America and Europe,[4–8] most probably related to genetic differences between the strains.[9]

Conflict of interest

No conflict of interest to declare.

References

1. Wheat LJ, Kauffman CA. Histoplasmosis. *Infect Dis Clin North Am* 2003;**17**:1–19.
2. Cunha VS, Zampese MS, Aquino VR, Cestari TF, Goldani LZ. Mucocutaneous manifestations of disseminated histoplasmosis in patients with acquired immunodeficiency syndrome: particular aspects in a Latin-American population. *Clin Exp Dermatol* 2007;**32**:250–5.
3. Thompson GR, La Valle CE, Everett ED. Unusual manifestations of histoplasmosis. *Diagn Microbiol Infect Dis* 2004;**50**:33–41.
4. Karimi K, Wheat LJ, Connolly P, Cloud G, Hajjeh R, Wheat E, et al. Differences in histoplasmosis in patients with acquired immunodeficiency syndrome in the United States and Brazil. *J Infect Dis* 2002;**186**:1655–60.
5. Couppié P, Clyti E, Nacher M, Aznar C, Sainte-Marie D, Carme B, et al. Acquired immunodeficiency syndrome-related oral and/or cutaneous histoplasmosis: a descriptive and comparative study of 21 cases in French Guiana. *Int J Dermatol* 2002;**41**(9):571–6.
6. Borges AS, Ferreira MS, Silvestre MT, Nishioka Sde A, Rocha A. Histoplasmose em pacientes imunodeprimidos: estudo de 18 casos observados em Uberlândia, MG. *Rev Soc Bras Med Trop* 1997;**30**(2):119–24.
7. Gutierrez ME, Canton A, Sosa N, Puga E, Talavera L. Disseminated histoplasmosis in patients with AIDS in Panama: a review of 104 cases. *Clin Infect Dis* 2005;**40**(8):1199–202.
8. Severo LC, Oliveira FM, Irion K, Porto NS, Londero AT. Histoplasmosis in Rio Grande do Sul, Brazil: a 21-year experience. *Rev Inst Med Trop Sao Paulo* 2001;**43**(4):183–7.
9. Goldani LZ, Aquino VR, Lunardi LW, Cunha VS, Santos RP. Two specific strains of Histoplasma capsulatum causing mucocutaneous manifestations of histoplasmosis: preliminary analysis of a frequent manifestation of histoplasmosis in southern Brazil. *Mycopathologia* 2009;**167**(4):181–6.